



**IL DEPARTMENT OF LABOR**

Fair Labor Standards Division  
Compliance Processing Section  
160 North LaSalle, Suite C-1300  
Chicago, IL 60601-3150  
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**One Day Rest In Seven Act  
Complaint Form**

**For Office Use Only**

File #:		
C. O. #:		
Type (Check one):	<input type="checkbox"/> Meal Period	<input type="checkbox"/> Six Day Week
County		
Code:		
Date		
Received:		

Please print/type all information: Use additional sheets if necessary and attach copies of all supporting documents.

Business Information:			
Name of Establishment:			
Owner or Contact Name if Known:			
Street Address (not a P. O. Box):			No. of Employees:
City:	State:	Zip Code:	
Business Telephone Number:	County:		
Describe Complaint:			
Complainant Information:			
Name of Complainant:			
Address:			
Daytime Telephone Number:	Confidential?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Complainant's Job Classification:			
Is the Complainant Covered by A Collective Bargaining Agreement?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**IF YOU HAVE ADDITIONAL INFORMATION, PLEASE INCLUDE WITH THIS FORM.**